# Appendix 1: Performance Measures (CDC Base All-Hazards Preparedness)

The following table describes a set of measures, targets, definitions, instructions, and a brief overview of data collection and submission methods. CDC will continue to require self-reported information as part of the technical reporting requirements for funded applicants. In addition, CDC will implement independent validation of self-reported information in this project period to ensure the validity and accuracy of the information. Additional guidance about phasing-in of measures will be forthcoming from CDC.

Grantees are required to report on the measures as described under data collection and submission methods. Although much of the information required for these measures can be obtained during commonly occurring urgent events (e.g., infectious disease outbreaks), grantees are expected to conduct drills and exercises to ensure that information is available for each of the measures described below. In addition, grantees should plan drills and exercises that stress their routine urgent response systems to ensure that they are building capacity for larger scale events. In each of these circumstances, grantees must implement data systems to accurately capture required information and self-report requested information to CDC. For some measures, data collected will include information from both CDC-conducted drills as well as grantee self-reported information, if available.

| CDC Preparedness Goal | Proposed Measure | Jurisdictional Target | Definitions & Other Guidance | Instructions | Jurisdictional Measurement Level | Data Collection and Submission Methods |
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| **PRE-EVENT** | | | | | | |
| **Goal 1: PREVENTION**<br><br>Increase the use and development of interventions known to prevent human illness from chemical, biological, radiological agents, and naturally occurring health threats. | 1. Public health agency has primary and secondary (backup) staff identified for core functional roles delineated in the Incident Command System (ICS) for public health | For 100% of core public health ICS functional roles, public health agency has documented contact information for primary and secondary (backup) staff | **Note:** The functional roles are:<br>• Incident Commander<br>• Public Information Officer<br>• Safety Officer<br>• Operations Section Chief<br>• Planning Section Chief<br>• Logistics Section Chief<br>• Finance/Administration Section Chief<br><br>Detailed descriptions of the functional roles and the Incident Command System can be found in "National Incident Management System," March 2004, available at: http://www.dhs.gov/interweb/assetlibrary/NIMS-90-web.pdf | **Numerator:** # of public health ICS core functional roles for which the public health agency has a documented list of contact information for primary and secondary (backup) staff<br><br>**Denominator:** 7 roles for both primary and secondary (backup) staff | State and local | Self-report data submitted semi-annually as part of CDC progress report.<br><br>Data submitted may be validated by an independent party during scheduled site visits.<br><br>State awardees should collect and report information for staff employed at the state-level and compile information from local public health agencies located within the MSAs described in the cooperative agreement guidance.<br><br>Local awardees will report on staff employed at the local public health agency only. |

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| **Goal 2: DETECTION AND REPORTING**<br><br>Decrease the time needed to identify health events that could result from terrorism or naturally-occurring events, in partnership with other agencies. | 2. Percent of HRSA National Bioterrorism Hospital Preparedness Program (NBPHPP) awardee hospitals that transmit clinical and/or hospital utilization data in near real-time to a PHIN-compliant early-event detection information system | 90% of HRSA awardee hospitals | **Definitions:**<br>Clinical data includes at least two of the following: patient chief complaint, physician diagnosis, or micro laboratory test orders and results.<br><br>Hospital utilization data includes the total number of staffed beds, the number of occupied beds, and the number of unoccupied beds; for the whole facility, and by facility unit.<br><br>Near real-time is defined to be 24 hours or less from the time clinical data is obtained to the time it is transmitted into the early event detection system.<br><br>In the 2006/2007 grant year, PHIN-compliant means that an awardee's implementation of information systems in the specified PHIN Functional Area(s) is PHIN Preparedness certified, or has minimally been base-lined for PHIN certification (i.e., validated). (Standards, self-assessment tools and certification process available at: http://www.cdc.gov/phin/certification/index.html). | **Numerator:**<br>Number of HRSA awardee hospitals that transmitted clinical and/or hospital utilization data within 24 hours from the time it was obtained to a PHIN-compliant early-event detection information system<br><br>**Denominator:**<br>Number of HRSA awardee hospitals<br><br>**Note:** If a hospital either did not transmit data within the last 6 months, or transmitted data, but not within 24 hours of receiving it, it will not be counted in the numerator. | State and local | Self-report data submitted annually as part of CDC progress report.<br><br>Data submitted may be validated by an independent party during scheduled site visits. |

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| | 3. Time to have a knowledgeable public health professional respond 24/7 to a call about an event that may be of urgent public health consequence. | Mean = 15 minutes | **Definition:**<br>Knowledgeable public health professional: Employee or contractor of the public health agency with an appropriate combination of education and experience to make basic inquiries of a caller to determine what level of call escalation should occur.<br><br>Call about an event that may be of urgent public health consequence: Call about an event that requires the immediate commitment of public health assets to further investigate and respond | **Start time:** Time that the call from the CDC DEOC first rings at the public health agency.<br><br>**Stop time**: Time that knowledgeable professional at the public health agency answers or returns the call.<br><br>**Note**: The recorded stop time will include any elapsed time due to call transfers, callback time, etc.<br><br>**Note:** CDC DEOC will use the public health agency's published phone number. | State and local | Data collected during ongoing CDC-initiated drills. Computed values for state-level awardees will include aggregated results for state public health agency and local public health agencies located the MSAs described in the cooperative agreement guidance. |

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| | 4. Time to initiate an epidemiologic investigation of an event that may be of urgent public health consequence. | Mean = 1 hour from notification of an event that may be of urgent public health consequence. | **Definition:**<br>Event that may be of urgent public health consequence: An event that requires the immediate commitment of public health assets to further investigate and respond.<br><br>**Note:** The initiation of an investigation includes taking action on any one of the following: designing or modifying data collection materials and databases, collecting health data, case finding, contact tracing, developing case descriptions, and identifying risk factors and populations at risk. | **Start time:** Time that public health agency receives a call about an event that may be of urgent public health consequence<br><br>**Stop time:** Time that public health agency epidemiologist initiates an investigation of the event.<br><br>Time includes contacting epidemiologist and assigning the investigation. | State and local | Self-report data submitted semi-annually as part of CDC progress report.<br><br>Data submitted may be validated by an independent party during scheduled site visits.<br><br>CDC will collect mean, median, minimum, and maximum times for events during the reporting period.<br><br>Awardees should keep paper and/or electronic log(s) that contains: 1) date and time from public health agency determination that an event may be of urgent public health consequence; and 2) date and time of beginning of epidemiological investigation and name of epidemiologist or designated official. |

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| | 5. Percent of Pulsed Field Gel Electrophoresis (PFGE) sub-typing data results submitted to the PulseNet national database within 96 hours of receiving isolate at the laboratory. | 90% of PFGE sub-typing data results are submitted to PulseNet within 96 hours | **Start time:** Date and time PFGE isolate is received (or agent is isolated in pure culture if lab processes clinical specimen) at the laboratory whether during working or off-duty hours<br><br>**Stop time:** Date and time pattern submitted to PulseNet server/team | **Numerator:** # of *E. coli* 0157:H7 and *L. monocytogenes* PFGE sub-typing results submitted to CDC's PulseNet database within 96 hours of receipt of isolate at the laboratory<br><br>**Denominator:** Total # of *E. coli* 0157:H7 and *L. monocytogenes* isolates PFGE pattern-analyzed. | State | Self-report data submitted quarterly as part of CDC progress report.<br><br>Data submitted may be validated by an independent party during scheduled site visits.<br><br>Information must include: Name of agent (i.e. *E. coli* 0157:H7 or *L. monocytogenes)*; date and time is received at the lab; date and time pattern analysis is completed; and date and time pattern submitted to PulseNet. |
| **Goal 3: DETECTION AND REPORTING**<br><br>Decrease the time needed to detect and report chemical, biological, radiological agents in tissue, food, or environmental samples that cause threats to the public's health. | 6. % of tested agents for which the Laboratory Response Network (LRN) reference labs passes proficiency testing | Reference labs has a passing rating for 100% of tested based on LRN - sponsored proficiency tests in which lab participated | Applies to funded LRN reference labs only.<br><br>Tested agents include those agents tested through LRN sponsored proficiency tests in which the lab participated. | Information will be collected as part of routine LRN proficiency testing. No additional reporting is required. | State | Data from CDC Bioterrorism Preparedness and Response LRN proficiency test reports.<br><br>Proficiency test results data will be collected separately for each agent tested at each funded LRN lab. |
| | 7. % of tested chemical agents for which Level 1 and 2 Laboratory Response Network (LRN) chemical labs passes proficiency testing | Level 1 and/or Level 2 chemical labs has a passing rating for 100% of tested chemical agents based on LRN-sponsored proficiency tests in which lab participated | Applies to funded Level 1 and 2 LRN labs only.<br><br>Tested chemical agents include those agents tested through LRN sponsored proficiency tests in which the lab participated. | Information will be collected as part of routine LRN proficiency testing. No additional reporting is required. | State | Data from CDC National Center for Environmental Health LRN proficiency test reports.<br><br>Proficiency test results data will be collected separately for each agent tested at each funded LRN lab. |

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| | 8. Time from shipment of clinical biological specimens to receipt at a LRN reference laboratory. | Mean = 6 hours | **Note:** Report data only on shipments of clinical specimens that potentially contain agents thought to be of urgent public health consequence.<br><br>LRN reference labs and clinical laboratories must negotiate agreements to ensure that the level and credibility of potential threats can be discussed to determine the urgency.<br><br>Urgent public health consequence: An event that requires the immediate commitment of public health assets to further investigate and respond. | **Start time:** Time that clinical biological specimen or culture of agent of urgent public health consequence is ready for shipment from sentinel lab to reference lab.<br><br>**Stop time:** Receipt of clinical biological specimen or sample containing an agent of urgent public health consequence at LRN reference lab. | State and local funded LRN reference labs | Self-report data submitted quarterly as part of CDC progress report.<br><br>Data submitted may be validated by an independent party during scheduled site visits.<br><br>Grantee should collect and report data for each reference lab located within its jurisdiction.<br><br>Mean, median, minimum, and maximum times from shipment to receipt for all shipments made during the reporting period will be collected.<br><br>Receiving labs should record the information from the chain of custody documentation to include: 1) date and time, 2) originating lab name and location, and 3) shipment description/code. |

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<td>9. Time from presumptive identification to confirmatory identification of select agents by Laboratory Response Network (LRN) reference lab.</td>
<td>Targets from presumptive to confirmatory identification:<br><br>Bacillus anthracis: <4 days<br><br>Francisella tularensis: <7 days<br><br>Yersinia pestis: <6 days</td>
<td>Note: The following presumptive identification times are provided as general guidance. Although presumptive identification is not currently being measured, grantees should strive to reach these time frames:<br><br>Presumptive identification times (minimum/maximum):
<table>
<tr><th>Agent</th><th>Minimum</th><th>Maximum</th></tr>
<tr><td>Bacillus anthracis</td><td>6 hours</td><td>24 hours</td></tr>
<tr><td>Francisella tularensis</td><td>6 hours</td><td>24 hours</td></tr>
<tr><td>Yersinia pestis</td><td>6 hours</td><td>24 hours</td></tr>
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</td>
<td>Start time: Time LRN reference lab determines presumptive identification of agent<br><br>Stop time: Time confirmatory identification is made</td>
<td>State and local funded LRN reference labs</td>
<td>Self-report data submitted semi-annually as part of CDC progress report.<br><br>Data submitted may be validated by an independent party during scheduled site visits.<br><br>Information should include: 1) type of agent; 2) date and time of presumptive identification; and 3) date and time of confirmatory identification.</td>
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<td>10. Time to have a knowledgeable Laboratory Response Network (LRN) reference laboratorian respond to a call during non-business hours.</td>
<td>Mean = 15 minutes</td>
<td>Non-business hours include before 8AM and after 5PM on weekdays and anytime on weekends and holidays.<br><br>Knowledgeable laboratorian: Employee or contractor of the reference laboratory with an appropriate combination of education and experience to make basic inquiries of caller to determine what level of escalation should occur.</td>
<td>Start time: Time that a call from the CDC DEOC first rings at the LRN reference lab or on-call duty officer.<br><br>Stop time: Time that knowledgeable LRN reference laboratorian responds to or returns the call.<br><br>Recorded stop time will include any elapsed time due to call transfers, callback time, etc.</td>
<td>State and local funded LRN reference labs</td>
<td>Data collected during semi-annual CDC-initiated drills.</td>
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| **Goal 4: DETECTION AND REPORTING**<br><br>Improve the timeliness and accuracy of communications regarding threats to the public's health. | 11. Time LRN reference lab generates confirmatory result for an agent of urgent public health consequence to notification of appropriate officials. | Mean = 2 hours | **Definitions:**<br>Agent of public health consequence: agents requiring immediate notification per LRN and state/local policy.<br><br>Appropriate officials: Include, at a minimum, State public health agency director or designee and local public health agency director or designee in the community in which the affected individual resides and the person or agency that submitted the specimen/sample for testing.<br><br>**Note:** Data to be collected from public health LRN reference labs. Confirmatory identification includes both positive and negative results. | **Start time:** Time that a confirmatory identification of an agent of urgent public health consequence is made.<br><br>**Stop time:** Time that public health director or designated official acknowledges receipt of the result | State and local | Self-report data submitted quarterly as part of CDC progress report.<br><br>Data submitted may be validated by an independent party during scheduled site visits.<br><br>CDC will collect start and stop times for each event during the reporting period.<br><br>LRN information should include (at a minimum): 1) name of agent tested; 2) date and time of confirmatory identification; 3) notification date and time; 4) name/city of agency/agencies notified; and 5) name/title of notified official. Lab should maintain and submit requested data for each relevant event during the reporting period.<br><br>Notified agency/agencies information should include: 1) date and time of notification; 2) name/city of notifying agency; and 3) agent and lab confirmatory result. |
| **EVENT** | | | | | | |

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| **Goal 5: INVESTIGATION**<br><br>Decrease the time to identify causes, risk factors, and appropriate interventions for those affected by threats to the public's health. | 12. Time for State/territory public health agency to notify local public health agency, or local to notify State, following receipt of a call about an event that may be of urgent public health consequence | Mean = 60 minutes from notification of an event that may be of urgent public health consequence. | **Definitions:**<br>Call about an event that may be of urgent public health consequence: Call about an event that requires the immediate commitment of public health assets to further investigate and respond.<br><br>Note: Applies to those calls where the call-taker determines that the event may be of urgent public health consequence and a commitment of assets is required | **Start time:** Time that public health agency receives a call about an event that may be of urgent public health consequence and warrants involvement of their state or local counterpart.<br><br>**Stop time:** Time when public health agency notifies its counterpart at the next level (e.g. State notifies local or local notifies State). | State and local | Data collected during semi-annual CDC-initiated drills and self-reported data submitted semi-annually as part of CDC progress report.<br><br>Awardees should keep either a paper or electronic log, regardless of the mode of communication used.<br><br>Notifying agency's log should contain: 1) name(s) of agency/agencies to which notification was made, 2) date and time<br><br>Receiving agency's log should contain: 1) name of agency notification was received from, 2) date and time<br><br>State awardees will report on calls made to local public health agencies; locals will report on calls made to the state public health agency. |

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| **Goal 6: CONTROL**<br><br>Decrease the time to needed to provide countermeasures and health guidance to those affected by threats to the public's health. | 13. Time to distribute a health alert to key response partners of an event that may be of urgent public health consequence. | Mean = 6 hours from the time a decision is made to notify partners | **Definition:**<br>An event of that may be of urgent public health consequence: An event that requires the immediate commitment of public health assets to further investigate and respond.<br><br>Key public health response partners: To be defined by the jurisdiction but should include, at a minimum, emergency management, hospitals, fire, police, and the jurisdiction's EOC. | **Start time:** Date and time that a decision is made to issue a health alert<br><br>**Stop time:** Date and time that public health agency sends a health alert to response partners | State | Self-report data submitted semi-annually as part of CDC progress report.<br><br>Data submitted may be validated by an independent party during scheduled site visits.<br><br>CDC will collect mean, median, minimum, and maximum times for events during the reporting period.<br><br>Awardees should keep paper and/or electronic log(s) that contains: 1) date and time that determination is made that an event may be of urgent public health consequence and that a health alert is needed; 2) date and time of a health alert is distributed to key public health response partners; and 3) name of response partner(s) that should receive the health alert. |

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| | 14. Percent of clinicians and public health response plan partners who receive public health emergency communication messages | 70% of clinicians and public health partners receive messages within the specified time. | **Definitions:**<br>Public health response partners comprise functional groups or roles defined by the jurisdiction and might be listed in the agencies emergency response plan.<br><br>Delivery time and whether acknowledgement is required or not are sender-specified attributes (see Partner Communications and Alerting Functional Requirements, PHIN Preparedness, Version 1.0). When acknowledgements are required, "delivery time" includes time for acknowledgement. Available delivery times are: 1) within 15 minutes; 2) within 60 minutes; 3) within 24 hours; and 4) within 72 hours.<br><br>**Note**: In this context, a message is classifies as "received: if an acknowledgement is made by the recipient within the time specified in the message. The time specified will vary based on the level of urgency of the message.<br><br>**Note:** In this context, "clinicians" refer to clinicians listed in the public health agency's Health Alert Network database. | **Numerator:** # of clinicians and response plan partners that acknowledge message within the specified delivery time.<br><br>**Denominator:** Total # of health alert messages sent that required acknowledgement. | State | Awardees should collect information by drilling or exercising the notification/acknowledgement process at least semi-annually and reporting the information semi-annually as part of CDC progress report.<br><br>Data submitted may be validated by an independent party during scheduled site visits.<br><br>Data sources may include computer-generated electronic message transmittal and acknowledgement times and/or paper records of acknowledgments phoned or radioed in. |

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| | 15. Percent of key public health response partners who are notified via radio or satellite phone when electric grid power, telephones, cellular service, and Internet services are unavailable. | 75% of response partners acknowledge message within 5 minutes of communication being sent | **Definitions:**<br>Key public health response partners: To be defined by the jurisdiction but should include, at a minimum, emergency management, hospitals, fire, police, and the jurisdiction's EOC.<br><br>**Note:** This does not imply simultaneous contact with all response partners. Rather, it is assumed that each partner will be contacted sequentially and respond within 5 minutes of communication being sent.<br><br>**Note**: Any system that will enable communications to occur between public health and its key response partners when power, phones, etc. are unavailable, e.g. satellite phone, radio, communication equipment able to be powered by a generator, can be used to address this measure. | **Numerator:** # of response partners who acknowledge receipt within 5 minutes of communication being sent<br><br>**Denominator:** # response partners to whom communication was sent<br><br>. | State and local | Awardees should collect information by drilling or exercising the notification/acknowledgement process at least quarterly and reporting the information semi-annually as part of CDC progress report.<br><br>Data submitted may be validated by an independent party during scheduled site visits. |

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| | 16. Time to notify all primary staff (secondary or tertiary staff as needed) with public health agency ICS functional responsibilities that the public health agency's Emergency Operations Center (EOC) is being activated. | Mean = 60 minutes | **Note:** The public health agency should have a pre-identified list of primary, secondary, and tertiary personnel required to staff its EOC upon initial activation. | **Start time:** Time that public health director or designated official sends notification that the public health agency's EOC will be activated.<br><br>**Stop time:** Time that final pre-identified primary (secondary or tertiary as needed) staff member with ICS functional responsibilities acknowledges the notification. | State and local | Awardees should collect information by drilling or exercising the notification process at least semi-annually and reporting the information quarterly as part of CDC progress report.<br><br>Data submitted may be validated by an independent party during scheduled site visits.<br><br>Awardees should keep paper and/or electronic log(s) or other documentation that contains: 1) date and time public health director sends notification of intent to activate EOC; and 2) date and time acknowledgement of notification is received from each person in core EOC staffing group. |

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| | 17. Time for primary staff (secondary or tertiary staff as needed) with public health agency ICS functional responsibilities to report for duty at public health agency's Emergency Operation Center (EOC). | Mean = 2 ½ hours from time that public health director or designated official receives notification that the public health agency's EOC will be activated. | **Note:** The intent is that each functional area is staffed. Therefore, only the primary person OR his/her backup (secondary or tertiary, if necessary) should be included in personnel count.<br><br>Awardees should have a pre-identified list of core staff required to staff the public health agency's EOC upon initial activation. | **Start time:** Time that public health director or designated official sends notification that the agency's EOC will be activated.<br><br>**Stop time:** Time when the last primary public health agency staff member with ICS functional responsibilities is signed in (physically or electronically) at the public health agency's EOC. | State and local | Awardees should collect information by drilling or exercising the notification process at least quarterly and reporting the information semi-annually as part of CDC progress report.<br><br>Data submitted may be validated by an independent party during scheduled site visits.<br><br>Awardees should keep paper and/or electronic log(s) or other documentation that contains: 1) date and time public health director sends notification of intent to activate EOC; and 2) date, and time each person in core staffing group signs in at EOC. |

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| | 18. Time to issue critical health message to the public about an event that may be of urgent public health consequence | Mean = 6 hours from the determination that a public message is needed | **Definition:**<br>An event of that may be of urgent public health consequence: An event that requires the immediate commitment of public health assets to further investigate and respond.<br><br>Critical health message: Message to the public issued that contains information about the event, status, recommended protective actions, and commitment to communicating updates. Examples of ways of issuing messages include information to clinicians via web sites, listservs, etc.; hotlines; press releases; and/or outreach to special population groups. | **Start time:** Time that a decision is made to issue a critical health message to the public<br><br>**Stop time:** Time that public health director or designated official issues the first critical health message. | State and local | Self-report data submitted semi-annually as part of CDC progress report.<br><br>Data submitted may be validated by an independent party during scheduled site visits<br><br>Awardees should keep paper and/or electronic log(s) or other documentation that contains: 1) event type and brief description; 2) date and time from public health agency determination that an event may be of urgent public health consequence AND a public message is needed; 3) Date and time decision is made to issue critical health message to public; 4) date, time, and mechanism through which the public health message is issued to the public; and 5) Date and time that public health director or designated official issues first critical health message. |

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| | 19. Adequacy of State and local plans to receive and dispense medical countermeasures as demonstrated through assessment by the Strategic National Stockpile/Cities Readiness Initiative (CRI) | Agency has a passing rating on 100% of all elements and functions based on its most recent Strategic National Stockpile/Cities Readiness Initiative (CRI) assessment | **Definitions:**<br>A Strategic National Stockpile/Cities Readiness Initiative Assessment is an onsite evaluation conducted by CDC SNS program staff. | Information will be collected as part of routine SNS/CRI assessment. No additional reporting is required. | State and local | Data collected annually from CDC SNS/CRI assessment reports.<br><br>The SNS/CRI rating for each element/function assessed will be collected separately for each awardee. |
| | 20. Time to issue an isolation or quarantine order | Mean = 3 hours from the decision that an order is needed | | **Start Time:** Time that public health agency determines that isolation or quarantine is needed<br><br>**Stop time:** Time that governor or legally-authorized authority signs an isolation or quarantine order | State and local | Self-report data submitted annually as part of CDC progress report.<br><br>Awardees should collect data in drills, exercises, or real events conducted at least annually.<br><br>Data submitted may be validated by an independent party during scheduled site visits. |
| **POST-EVENT** | | | | | | |

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| **Goal 7: RECOVER**<br><br>Decrease the time needed to restore health services and environmental safety to pre-event levels. | 21. Time to issue guidance to the public after an event | Mean = 6 hours from the time a decision is made to provide recovery-related information to the public | **Definition:**<br>Guidance: Public health protection information related to air, food, safety, soil, and vector control issued to notify the public of precautionary or protective actions that they can take following an event. | **Start time:** Time that a decision is made to provide recovery-related information to the public<br><br>**Stop time:** Time that public health director or designated official first provides recovery-related information to the public after an event has occurred | State and local | Self-report data submitted semi-annually as part of CDC progress report.<br><br>Data submitted may be validated by an independent party during scheduled site visits.<br><br>Awardees should keep paper and/or electronic log(s) or other documentation that contains: 1) event type and brief description; 2) date and time that a decision was made to provide recovery-related information to the public; and 3) date and time that the public health director or designated. |
| **Goal 8: RECOVER**<br><br>Improve the long-term follow-up provided to those affected by threats to the public's health. | No Measure | | | | | |

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| **Goal 9: IMPROVE**<br><br>Decrease the time to needed to implement recommendations from after-action reports following threats to the public's health. | 22. Time to complete an After-Action Report (AAR) with corrective action plan(s). | Mean = 60 days from conclusion of an exercise or real event | The AAR should include a prioritized list identifying the top five items that are exclusively public health-related for corrective action and corresponding time-line for implementation.<br><br>The top five items should be determined by prioritizing items by the potential for loss of life, injury, or property damage. | **Start time:** Date of the day following public health agency's EOC deactivation after the drill, exercise, or real event.<br><br>**Stop time:** Date AAR is sent to public health agency director or designated official. | State and local | Self-report data submitted semi-annually as part of CDC progress report.<br><br>Data submitted may be validated by an independent party during scheduled site visits.<br><br>The public health agency director or designated official should keep paper or electronic copies of AARs for all events that occur during the reporting period (including date of receipt of AAR). |
| | 23. Time to re-evaluate area(s) requiring corrective action. | Mean = 180 days after AAR is completed. | Note: The aim is for re-evaluation of area(s) requiring corrective action that may be exclusively related to the public health agency's planning and/or operations. | **Start time:** Date and time AAR is sent to public health agency director or designated official.<br><br>**Stop time:** Date and time drill or exercise is held to re-evaluate at least one of the top five items identified in the corrective action plan reported in performance measure #22. | State and local | Self-report data submitted semi-annually as part of CDC progress report.<br><br>Data submitted may be validated by an independent party during scheduled site visits. |